Katherine Fisher's problem free feed method©

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About the author

Katherine Fisher is an International Board Certified Lactation Consultant with 19 years continuous registration, she was also an NCT Breastfeeding Counsellor for 20 years.

Katherine is a Lactation Consultant who specialises in:

- Diagnosis, assessment and treatment of various types of ankyloglossia (Tongue-Tie)
- Breastfeeding for mothers and babies with additional needs
- Complex feeding difficulties
- Treatment of nipple trauma
- Breast hypoplasia and Breastfeeding after breast surgery
- Transition from formula feeding to Breastfeeding
- Breast refusal
- Transition to formula feeding
- Baby weight gain issues
- Maternal medical issues relating to Breastfeeding
- Supplemental feeding
- Sleep and settling difficulties
- Hypoprolactimea and hyperprolactimea
- Re-lactation and initiating lactation for adoption
- Antenatal expression

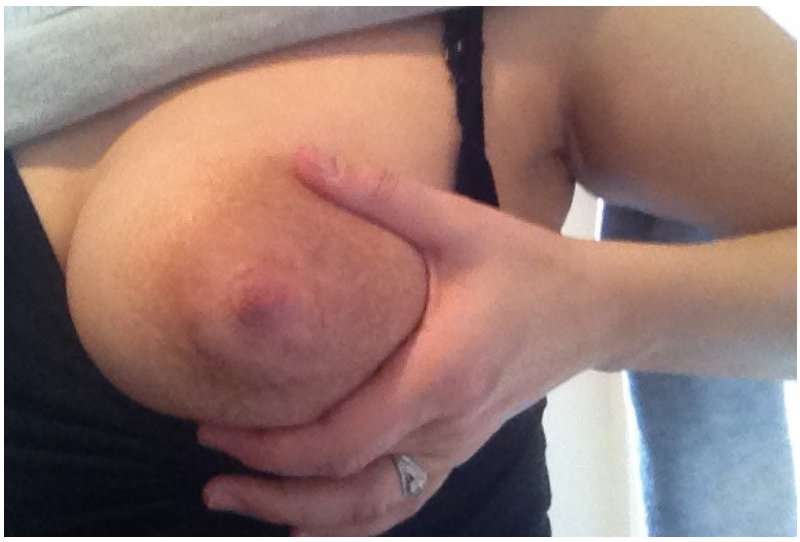
Katherine is the Team Leader of a large NHS Tongue-Tie Service. She also has an independent private practice and joint private practice with a consultant paediatric surgeon offering Lactation Consultancy and frenulotomy.

The problem free feed method

The Breastfeeding method detailed below should ensure that you attain a clear beginning and end to your feeds, with some time in-between. The method has evolved through my work with thousands of families, and draws on the anatomical and physiological aspects of Breastfeeding, bringing together a natural method that really makes a difference. The hundreds of parents I have worked with have found my method to be invaluable, Good Luck!

1. Get your baby and breast correctly positioned

Get baby ready and whatever position you choose, you need to gently position your thumb on one of baby's ears and either of your 2nd and 3rd fingers on their other ear. This ensures that you support and stabilise the position of the head without applying pressure to it. The palm of your hand should be on baby's back/shoulders and this will provide the pressure /movement for bringing baby to the breast (try not to take the breast to the baby!)



Get your breast ready by holding it in a C shaped hold with the hand on the same side as your breast. You should be able to feel your ribs with your little finger the other 4 fingers should form a 'shelf' for your breast and

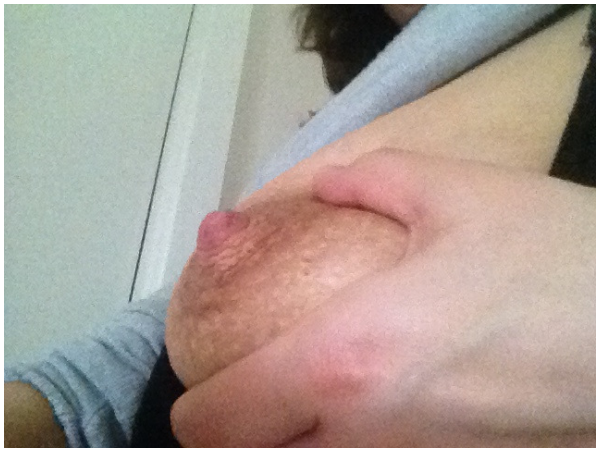
your thumb should be on the top of the breast close to the areola but not on it.

2. Achieving the correct latch

Keeping baby and breast still, rest your nipple on either baby's top lip or the philtrum (the groove under the nose) try not to waggle your nipple/breast about. Baby's bottom lip needs to be fairly close to the areola /breast tissue margin. As baby begins to open their mouth, bring their lower jaw down and to extend their tongue towards/over the bottom lip, quickly bring baby onto the breast, your nipple needs to sit under baby's soft palate, if you can do this the remainder of the areola will follow. (It is not necessary to get all the areola in the mouth!). Don't wait for a fully open mouth/ gape as it is very transient and baby will only close it again very quickly!

In these pictures you can see (on the left) the nipple resting on the grove under the nose, baby has a nice big gape, as he moves forward to latch (right picture) the bottom lip is rolled back and about to meet the areola breast tissue margin. If you have very wide areola, aim for two finger widths from the base of the nipple.

Another way to encourage the correct latch is to place a finger (or in the picture right a thumb) on the areola and this will tilt the nipple upwards, this is called an exaggerated latch, or nipple tilt, you can still follow the above steps.



3. Check the latch

Once baby is on you may feel some discomfort that will last for approximately 30 seconds - this is normal. However, if the discomfort continues and cannot be improved by bringing baby closer (by applying gentle pressure to the back with the palm of your hand) the latch is wrong and needs assessment.

Your nipples need to look more or less the same when they come out of the baby's mouth as when they went in, if they are squashed or distorted the latch is wrong, or your baby needs an oral assessment to determine whether or not they have a Tongue-Tie, or their palate is vaulted or spoon-shaped. These things are common/ normal and you and your baby can be helped to successful Breastfeeding by an experienced Lactation Consultant.

A perfect latch – note the cheeks in contact with the breast, they are full without being sucked in

4. Simulate additional let down and milk transfer

In the early days undertaking breast compressions during the feed is very important and can reduce the necessity to use supplements by stimulating milk let downs and ensuring that there is calorific gain at each feed. Breast compressions involve pushing your thumb and fingers together whilst in a C shaped hold around the breast. The compression is firm and slow, if you do it too quickly it yanks the nipple out of baby's mouth or gives baby too large a squirt of milk!

Breast compressions also ensure that baby does nutritive suckling throughout the feed and prevents the baby falling asleep or drifting off into non-nutritive or comfort suckling. You only need to compress when baby is not suckling and ensure that you give the baby time to respond to the compression.

Do not poke, pinch or blow on baby during the feed to wake them up just do breast compressions. You can read more information and see video clips of breast compressions on the International Breastfeeding Centre website at http://www.nbci.ca/ under the menu 'Information sheets and videos – information sheets English', or search for Dr Jack Newman Breast Compression within You Tube.

Once Baby is suckling competently and transferring milk, you can slowly and gently change hands, placing one on baby's bottom, freeing the other hand for breast compressions.

5. Knowing when the feed is finished

You will know when baby has approached the end of potentiality for further milk let downs when: they do not respond to two consecutive compressions, fall asleep, or drop off spontaneously. The words 'empty', 'finish', 'drain' are not useful to describe what happens during a feed, and hind milk is available within about 6-8 suckles.

Another way to tell if the baby has accessed all they are able to from the breast or is satiated, is to gently loosen the pressure from the palm of the hand on the baby's back. If the baby falls off the breast, the feed on that breast is finished, if the baby returns aggressively to feeding- then it is not!

How long each feed will take is very specific to the mother and baby, the best guide particularly in the early days is the baby's response to breast compressions.

Talk to your Lactation Consultant, Breastfeeding Specialist, Midwife or Health Visitor to show you how to feed your baby in more upright biological nurturing positions as below.

6. Winding

Once baby has had one breast it is important to sit baby upright with the oesophagus is in a vertical position, do not underestimate the importance of this. There is no need to 'wind' the baby by vigorous rubbing and patting of the back. Simply supporting baby in an upright position allows the weight of the feed to displace any air, and for the feed to settle lower in the stomach. This leaves more room for milk from the second breast.

7. Offer the second breast

By this time the baby should perhaps be making some pre-feeding behaviours even if they are not it is important to offer the second breast at each feed. If the baby wants to feed from the second breast, follow steps 1-6.

8. Post feeding behaviour

This next bit is vital; babies exhibit pre and post feeding behaviors that look exactly the same! These behaviors include hands in the mouth and rooting, this does not mean that the baby is hungry; they just need to do some non-nutritive (comfort) sucking. This type of sucking iniates peristalsis necessary to keep stomach contents going the right way and to prevent false satiety (full up) cues.

Wrap or swaddle baby and offer your finger pad side up (or soother if it's your choice) putting it in

baby's mouth to the first joint. Baby will suck very vigorously at first, do not worry; the suckling should de-escalate and baby should fall asleep. If the suckling/distress escalates you may need to put baby back to the breast or supplement with expressed breast milk. If you find you are using your finger a lot you may want to consider the use of a soother for post feed non-nutritive sucking. However constant use of a soother at other times may mean that you miss important feeding cues.

This is only a brief guide and your baby is unique, if this method is not helping you, please contact me using the information below. There may be other issues that require evaluation for example - Tongue-Tie, low milk supply or poor positioning and attachment technique.

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